Original article

Impediments of health seeking behavior and health service utilization from healthcare facilities in a rural community in East Gojjam Zone, Ethiopia

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Abstract

Background: There is a burgeoning literature on health seeking behaviors and the determinants of health services utilization especially in the context of under developed countries. Underutilization of the health services is also almost a universal phenomenon. Even by African standards, Ethiopia has one of the least health status indicators and the health service coverage is generally very low.

Objectives: To examine the socio-cultural and demographic deterrents of health seeking behavior and health service utilization in the rural community in East Gojjam Zone of Amhara Region.

Methods: This study employed both quantitative (household survey) and qualitative (FGDs, in-depth and key informant interviews) methods to collect relevant data. Descriptive and inferential statistics was used to analyze the quantitative data. The qualitative data was analyzed thematically and presented concurrently with quantitative data.

Findings: Individual level demand related factors and structural level supply related factors that were embedded in the healthcare institutions; cultural practices and religious orientations of the community were identified as impediments health service utilization. The easily accessible, acceptable, socially and culturally closer and less bureaucratic indigenous medicines have instead drawn attention to health service use as compared to healthcare institutions.

***Conclusion*:** This study contends that health seeking behavior and health service utilization from healthcare institutions of rural communities is the product of the interaction of plethora agency and structural level factors. Addressing both agency and structural issues will have far-reaching implications in promoting the health seeking behavior of the rural communities. [*Ethiop. J. Health Dev.* 2015;29(2):99-110]

Introduction

The factors that determine the health seeking behaviour could be seen from various contexts; physical, socio-economic, cultural and political points of view (1-3). Therefore, the utilization of the existing healthcare system, public or private, formal or informal, might depend on socio-demographic factors, social structures, cultural beliefs and practices, economic and political systems, environmental conditions, distance to health care disease patterns and healthcare system (3-5). Moreover, indigenous healthcare services are readily available and compete with orthodox health care posing a serious challenge for the utilization of health services from modern healthcare institutions (6). Consequently, health service utilization is threatened by the effect of both individual and societal level factors (7).

Previous studies in Ethiopia have uncovered the dynamics of health seeking behavior and health service utilization by investigating the various aspects of maternal health seeking behavior and service utilization for childhood illness. A number of studies (8-12) were done on maternal health seeking behavior and service utilization for childhood illness in Ethiopia. These studies discussed factors like women's autonomy, knowledge about the causes of illness and economic impediments of health seeking behavior and service utilization. Other studies on health seeking behavior (13-17) concentrated mostly on clinical settings, explored the determinants of health service utilization and health seeking behavior for selected diseases. A study conducted on health service utilization in Amhara Region (18) revealed that most of the rural residents failed to visit healthcare institutions due to lack of knowledge on disease etiology. They resort to over the counter drugs and visit to traditional healers. But this study failed to address the socio-cultural barriers to seeking and utilizing modern healthcare services. Another study explored health seeking behavior in Ethiopia (19) with an emphasis on when and where to seek care for five context specific clinical vignettes. It disclosed the correlation between socio-economic status of patients and preference of modern healthcare providers as well as delay to seek care for perceived symptoms. Thus, more affluent people sought care immediately as compared to the poor and their first choice was private health centers. The main reason for the variation in seeking health service was affordability instead of lack of knowledge.

The aforementioned studies demonstrated the complexity of different micro-level factors that influence individual's health seeking behavior. They

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focused almost exclusively on two segments of the population, namely women and children, with disease specific orientation at the expense of other segments of the population and generic ailments. It appears that these studies were within the domain of Millennium Development Goal (MDGs) targets of Ethiopia. The previous studies also overlooked the structural barriers of health seeking behavior by overemphasizing agency or individual's behavior. There is a burgeoning concern that factors promoting good health seeking behavior are not only rooted solely in the individual but also in broader structural issues (20). Furthermore, the studies on health seeking behavior and health service utilization conducted in Ethiopia to date were primarily carried out by those individuals from medical sciences. Medical professionals preferred clinical settings which could obscure the sociological underpinnings and insights about the socio-cultural barriers of healthcare seeking behavior and the perceptions of the community regarding modern healthcare services. The present study addresses this gap and investigates health seeking behavior and health service utilization at community level with the aim to explore the socio-cultural and demographic barriers to health seeking and services utilization.

This study employed the socio-behavioral model of health service utilization by Anderson (21), which is one of the most comprehensive explanatory models. The model outlined three main determinants of health service utilization under the general headings of predisposing, enabling and need factors. It offers a framework which includes both societal and individual determinants of utilization. In doing so, it has provided a roadmap in the identification of barriers to healthcare services utilization and health seeking behavior.

Methods

Study Area: The study was carried out in *Enebise Sar Mider woreda* of East *Gojjam* Zone, *Amhara* Regional State of Ethiopia. According to the projection by (CSA 2013), the study *woreda* had a predicted total population of 154, 108 in 2014. From this, 75,962 are male and 78,146 are female population, as well as 18,149 dwellers and 135, 959 are living in urban and rural areas respectively. Farming is the major livelihood strategy and about 92% of the populations of the woreda rely on farming as a means of livelihood. The major farm activity is crop production followed by animal husbandry. The area was selected because of first author's familiarity with the area and anticipated convenience to access informants.

Study Design: Cross-sectional study design was employed and the study was carried out from February 14, 2015- March 25, 2015. Relevant retrospective data on health seeking behavior for an illness episode occurred in the past was also generated.

Household survey, FGDs, key informant and in-depth interviews were carried out. The survey was conducted to understand the attitude of the study participants about modern healthcare services, institutions and health care. Interviewer administered questionnaire was employed to collect survey data. In the questionnaire, one scale was included to measure attitude of the study participants. The scale has 10 Likert scores each having four categories varying from strongly agree to strongly disagree. Responses to these items were summed up to create an overall score for each respondent. The scores of the scale varied from 10 - 40 points and were classified into two levels based on the 60-80% cut off point (22), as Negative Attitude 10 – 27 scores (Less than 70%), and Positive Attitude 28 - 40 scores (70%-100%).Three research assistants were recruited and trained to administer the survey with close supervision by the first author. The first author collected all the qualitative data with the help of local guides and interviews were done with health professionals, religious leaders and elderly inhabitants. A total of nine FGDs comprising of youths, adult women and men from the three kebeles were conducted separately. In-depth interviews with selected youth and adult men and women patients were conducted to generate illness narratives such as how they managed their illness and the way they responded to illness symptoms and the subtle socio-cultural barriers of seeking health and service utilization.

Study Population, Sample size and Sampling: Study participants were composed of rural households, health professionals, religious leaders and elderly of the community. The study participants were recruited by employing both probability and non-probability sampling designs. The rural *kebeles* of the study *woreda* were stratified in to three agro-ecological zones (*Dega, Woinadega and Kola*) assuming varied distribution of diseases, psycho-social characteristics and ways of life in these agro-ecological zones. Lottery method was used to select one sample *kebele* from each agro-ecological zone. Taking the homogeneity of the study population in to consideration, 180 households 60 from each study *kebele* were included in the study. The actual households for the survey were recruited by employing systematic sampling technique based on the sampling frame acquired from the administrations of each selected *kebele*. Finally, at household level either the head or spouses of the head of the households were randomly recruited for the study. The informants of qualitative research were recruited by using purposive sampling technique. Accordingly, nine health professionals, three religious leaders and five elderly were recruited as key informants. Moreover, eight patients were selected from health facilities for case study.

***Methods of Data Analysis*:** The quantitative data were analyzed by using descriptive statistics such as frequency, percentages and mean distribution. T-test, Chi-square and One-Way ANOVA were administered to make statistical test and inference of the quantitative data. The statistical analysis tool SPSS version 20.0 was employed for analysis. The qualitative data were summarized and presented concurrently alongside with the quantitative data by using thematic analysis technique.

Study Framework: This study employed a model developed by Andersen (1995) called socio-behavioural model (SBM) of health service utilization, which is one of the most comprehensive explanatory models. The three basic determinants of health service utilization are conceptualized as follows. Predisposing factors are those characteristics that exist prior to one's illness and which may affect need for services but not necessarily be the cause of utilization. Predisposing factors include demographic factors such as age and sex, social structural factors such as occupation, religious affiliation and education, and attitudinal factors such as attitude and beliefs. Enabling factors are conceptualized as those circumstances like family and community level resources which may facilitate the use of appropriate services once the need has been recognized. Need factors can include both perceived and evaluated needs of individual. According to Andersen (1995) perceived need is all about how people view their own general health and functional state, as well as how they experience symptoms of illness, pain and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek healthcare services.

Ethical Considerations: The study was approved by the Department of Sociology at Addis Ababa University. Oral consent was obtained from the participants and confidentiality was assured for any information provided.

Results

Socio- Demographic Characteristics of Respondents: According to table 1 below, 93(51.7%) of the respondents are male and the remaining 87(48.3%) were female. Majority of the respondents 67(37.2%) were found to be in the age group 41-55, followed by age groups 25-40 and 56-70 which comprises 49(27.2%) and 45(25%) respectively. The majority of the respondents 131(72.8%) were married and cannot read and write.

Table 1: **Socio-economic and Demographic Characteristics of Respondents**

		Frequency (N=180)	Percent	Mean	Standard Deviation
Sex	Male	93	51.7		
	Female	87	48.3		
	Total	180	100.0		
Age Group	25-40	49	27.2	51.9	14.919
	41-55	67	37.2		
	56-70	45	25.0		
	71-85	14	7.8		
	86-100	5	2.8		
	Total	180	100.0		
Marital Status	Married	131	72.8		
	Divorced	26	14.4		
	Widow/er	23	12.8		
	Total	180	100.0		
Educational Status	Can't read and write	131	72.8		
	Can read and write	38	21.1		
	Primary school complete	7	3.9		
	Secondary school and more	4	2.2		
	Total	180	100.0		
Family Size	≤ 5	100	55.6	5.44	2.048
	6-10	77	42.8		
	11-15	3	1.7		
	Total	180	100.0		

Health Seeking Behavior and Health service Utilization of Respondents: One hundred fifty two (84.4%) of the respondents reported on the occurrence of illness episode in the year preceding the survey. On the other hand, 162 (90%) of the respondents consulted their families or neighbors whenever they encounter illnesses. Those respondents, who reported consulting, were further asked to identify whom they consulted first about a possible course of action for their health problems. The majority 83(51.24%) of them reported to have consulted their families followed by 41(25.31%) and 14(8.64%) of respondents who consulted their God and friends respectively. A fairly large number of respondents 82(45.6%) took treatment actions after a week latter following the onset of illness. The reason for not taking actions immediately varied from person to person. The respondents' tardiness comes from their optimism of being well in a few days, and the extent to which the symptoms are perceived as dangerous and when such; symptoms disrupt family, work, and other social activities.

Table 2: **Health Seeking Behavior of Respondents**

		Frequency	Percent
Illness Episode in the Previous Year	Yes	152	84.4
	No	28	15.6
	Total	180	100.0
Consultation about illness encounter	Yes	162	90.0
	No	18	10.0
	Total	180	100.0
Whom was consulted first on illness encounter	Family	83	51.24
	Friends	14	8.64
	Spiritual Father	11	6.79
	GOD	41	25.31
	Medical Personnel's	13	8.02
	Total	162	100.0
How soon action is taken against illness encounter	Same Day	44	24.4
	After 2-3 Days	31	17.2
	After 4-5 Days	23	12.8
	After a Week	82	45.6
	Total	180	100.0
Do you Comply with suggested action	Yes	162	90.0
	No	18	10.0
	Total	180	100.0

Finding on health service utilization from healthcare institutions shows that 120(66.7%) of respondents regularly visited healthcare institutions when they feel ill. About 74(41.1%) of respondents reported no visit health care institutions in the previous year while 51(28.3%) and 44(24.4%) of the respondents visited healthcare institutions 4-7 and 1-3 times in the past year preceding the study. Those respondents who visited healthcare institutions were further asked to indicate the reason for their visit. The majority83 (78.31%) of respondents identified illness encounter as the main reason to visit health facilities while remaining 11(10.37%) and 12(9.44%) of respondents reported delivery and injury respectively.

Table 3: **Health Service Utilization from Healthcare Institutions**

		Frequency	Percent
Do you Visit Healthcare Institutions Regularly when you feel Ill	Yes	120	66.7
	No	60	33.3
	Total	180	100.0
How Many time did you have visited healthcare Institutions in the past year	No Visit	74	41.1
	1-3	44	24.4
	4-7	51	28.3
	8-11	11	6.1
	Total	180	100.0
Reasons for Visiting Health Facilities	Illness	83	78.31
	Injury	10	9.44
	Physical Check-up	2	1.88
	Delivery (Women only)	11	10.37
	Total	106	100.0
Preferences of health facility when Illness is encountered	Village Health Posts	13	7.2
	Health Centers	105	58.3
	Private Clinics	49	27.2
	District Hospitals	4	2.2
	Purchasing Over-the-Counter Drugs	9	5.1
	Total	180	100.0
Do you have a Diagnosed Chronic Illness/es	Yes	61	33.9
	No	119	66.1
	Total	180	100.0

Respondents were asked to identify the healthcare facilities they preferred to visit during illness. Most 105 (58.3%) of them noted health centers as their primary choice. Other significant number of respondents 49(27.2%) indicated private clinics as the ideal healthcare service providers for their illnesses. From the total respondents, 61(33.3%) reported to have been diagnosed for chronic illness. They were asked to state the name of their illness in an open ended question. Chronic illnesses like rheumatism, asthma, gastritis, back pain, eye problems, diabetes, kidney failure, cardiac problem, and hypertension were identified by the respondents. One in-depth interview informant narrated the prevalence of these illnesses as follows:

We did not have such new illnesses in the past. We, rural people were healthy and we did not even know health centers in the past. But, now things have changed rapidly and such chronic or other types of illnesses are knocking on everyone's door. After the introduction of manufactured edible oils and fertilizers, rural inhabitants are contaminated with innumerable illnesses. In the good old days we had plenty of butter and milk, which were the reasons for our stamina, but now such things are hardly available. The chronic illnesses are the result of fertilizers and edible oils (Male, 46).

Demographic Barriers of Health Seeking BehaVior and Health Service Utilization: The health seeking behavior of the two sex groups was scrutinized by employing Chi-square test. Results of the test revealed that the *P* value is significant at $\alpha = 0.01$. Men took treatment actions earlier than their female counterparts. The imbalance in decision making power of the two sexes could have contributed to this difference. The result test statistics on sex and health service utilization is significant at $\alpha = 0.01$. Moreover,

Table 4: **Predisposing Factors and Health Seeking Behavior**

	Predisposing Factors						
Length of time to take treatment action	**Sex**		**Age Group**				
	Male	**Female**	**25-40**	**41-55**	**56-70**	**71-85**	**86-100**
Same day	31(33.3%)	13(14.9%)	23(46.9%)	14(20.9%)	7(15.6%)	0(0.0%)	0(0.0%)
After 2-3 days	22 (37.7%)	9(10.7%)	12(24.5%)	10(14.9%)	9(20.0%)	0(0.0%)	0(0.0%)
After 4-5 days	12 (12.9%)	11(12.6%)	5(10.5%)	9(13.4%)	8(17.8%)	1(7.1%)	0(0.0%)
After a week	28 (30.1%)	54(62.1%)	9(18.4%)	34(50.7%)	21(46.7%)	13(92.9%)	5(100.0%)
Total	93(100%)	87(100%)	49(100%)	67(100%)	45(100%)	14(100%)	5(100%)
χ2	20.926**			42.401**			

	Predisposing Factors						
Length of time to take treatment action	**Marital Status**			**Educational Attainment**			
	Married	**Divorced**	**Widowed**	**Cannot Read and Write**	**Can Read and Write**	**Primary School Complete**	**Secondary School and Above**
Same day	42(32.1%)	2(7.7%)	0(0.0%)	18(13.7%)	18(47.4%)	6(85.75%)	2(50.0%)
After 2-3 days	29(22.1%)	2(7.7%)	0(0.0%)	21(16.0%)	9(23.7%)	0(0.0%)	1(25.0%)
After 4-5 days	20(15.3%)	2(7.7%)	1(4.3%)	19(14.5%)	3(7.9%)	0(0.0%)	1(25.0%)
After a week	40(30.5%)	20(76.9%)	22(95.7%)	73(55.7%)	8(21.1%)	1(14.3%)	0(0.0%)
Total	131(100%)	26(100%)	23(100%)	131(100%)	38(100%)	7(100%)	4(100%)
χ2	46.101**			42.187**			

***p< 0.05, **p<0.01**

The test statistics on age and health service utilization is significant at $\alpha = 0.05$. Thus age seem to have an impact on the utilization of health services and the respondents in the age group of 41-55 were more likely to use health services for their health disorders. This age is also a stage when people are approaching old, which is associated with various illnesses requiring visits to healthcare institutions more often than other age groups. Moreover, the result of the Chi-square test unveiled that age of individuals has a significant impact on the length of time to take treatment actions. The *P* value is significant at $\alpha = 0.01$(See table 4). One Way ANOVA statistical test was employed to examine the influence of marital status on health service utilization. The result of the test statistics showed that, there was no variation of health service use among married, divorced and widowed. There was no variation in visit of healthcare institutions across the marital status of respondents, but the length of time to take treatment actions after the onset of an illness was significant. The Chi-square test revealed that the *P* value is significant at $\alpha = 0.01$. Thus, it is possible to conclude that the married segments of the community take treatment actions for their maladies sooner than those who are either divorced or widowed. Living with ones intimate spouse appears pushing factor in the health seeking behavior spectrum of the rural dwellers.

Table 5: **Socio-demographic factors and health service utilization**

Predisposing Factors	Category	Mean (Health service utilization)	Test Statistics
Sex	Male	1.4	11.777**
	Female	4.15	
Age	25-40	1.71	2.714*
	41-55	2.66	
	56-70	1.78	
	71-85	2.50	
	86-100	.80	
Marital Status	Married	2.58	.77
	Divorced	3.08	
	Widow/er	3.17	
Educational Status	Can't read and write	3.09	3.346*
	Can read and write	1.66	
	Primary school complete	1.86	
	Secondary school and more	2.5	
Family Size	≤ 5	2.94	.909
	6-10	2.43	
	11-15	3.33	
Fear of visiting healthcare institutions	Yes	1.14	12.271**
	No	2.37	
Attitude	Negative	.74	19.758**
	Positive	3.77	

***p< 0.05, **p<0.01**

Educational attainment was found to have significant association with health service utilization. The P value is significant at $\alpha = 0.05$. Thus, there was a significant difference on the health service utilization pattern of rural residents across different educational status. Furthermore, the chi-square test revealed that the educational attainment has significantly predicted the length of time to take treatment action. *P* value is significant at $\alpha = 0.01$. *Length of time to take treatment action and family size of the household was not found to be associated.* The test statistics on family size is not significant at $\boldsymbol{\alpha} = 0.05$.

Socio-Cultural Barriers of Health Seeking Behaviour and Health Service Utilization:

Primary Action taken upon encounter of illness

Respondents were asked to identify actions they would take when feeling ill. Majority of respondents 75(41.7%) resorted to take home remedies. Another considerable number of respondents 47(26.1%) reported using holy water (*tsebel*) as an immediate action. The reason behind this action is faith and easily accessible holy water in monasteries and churches. Equally important is the experience of The study participants narrated hearing different stories preached in church about the power of holy water in healing strange and chronic illnesses. Thus, for many people in the study area, holy water is the archetype option to get rid of illness. About 41(22.8%) respondents reported visiting healthcare facilities as a first action of illness response. The remaining 16(8.9%) and 1(0.6%) of respondents preferred praying to the Lord and consulting traditional healers as their first line of action respectively.

Fear and Health Services Utilization: Some people feared to have a diagnosed illness and subsequent treatment. Respondents were asked whether they fear taking medicine/visiting healthcare facilities. Response shows that about 37(20.6%) responded affirmatively. The rest of the respondents 143(79.4%) did not fear to take medicine or to visit healthcare institutions. The P value of the T-test was significant at $\alpha = 0.01$. Thus, those individuals who did not fear to take medicine/visit healthcare institutions have better health seeking behavior. Those respondents who feared taking medicine and visiting healthcare facilities were asked to indicate the sources of their fear. Fear of contracting iatrogenic diseases, fear of treatment that might be recommended and fear or distrust of the modern medical facilities were indicated by the 21.12 % of respondents as reasons not to visit healthcare facilities. The other sources of fear emanates from mistreatment by the providers and privacy issues.

Table 6: **The First Action Respondents Took during Illness**

		Frequency	Percent
The First Action Respondents Took When Ill (either infectious or chronic)	Pray to the Lord	16	8.9
	Sprinkle Holy Water	47	26.1
	Take Home Remedies	75	41.7
	Consult Traditional Healer	1	.6
	Visit Healthcare Institutions	41	22.8
	Total	180	100.0

Table 7: **Sources of Fear of Taking Medicine and Visiting Healthcare Institutions**

What are the fears kept you from visiting healthcare providers (Multiple Responses are Possible)	Frequency (N=37)	Percent of Responses	Percent of Cases
Fear associated with the privacy	4	4.45	10.82
Fear or distrust of the modern medical facilities	19	21.12	51.35
Fear of treatment subscription	21	23.33	56.75
Fear or dislike of the provider	13	14.44	35.13
Fear of Contracting iatrogenic disease	33	36.66	89.18
Total	90	100	243.23

Demand Side Barriers of Health Service Utilizations: The demand side barriers are those that possibly come in from the constituency of health services or individual level and macro-level barriers outside the healthcare institution and/ or service providers. Majority of the respondents were either unable to pay medical expenses (85.6%) or perceive their own disease was not sever enough (71.7%) requiring treatment in healthcare institutions. Other fairly large number of respondents (65.6%) used holy water as a substitute of medical services for the treatment of their illness. Poverty seems one of the deterrent factors as people of the study area did not diversify their livelihood strategies and lacked additional sources of income besides crop production and animal husbandry. Other demand side factors such as knowing how to deal with illness by oneself, which is self-medication and having no free time were mentioned by 21.1% and 23.3% of respondents respectively. When something wrong happened, people in the study area used *aregresa*[1] , which is applied first for any maladies. One informant said; "Drenching *aregresa* is the usual practice for any ache and it is the quickest acting medicine which is easily accessed by the rural dwellers. A cup of *aregresa* is greater than a packet of *borenk*[2]." One female FGD Participant endorsed this by saying "*aregresa* was tasted by Saint Virgin Mary and given to us, so taking *aregresa*is usual practice in our community when we have pain." Since farmers are busy with seasonal chores, time constraint is another issue as described by a female informant:

In the time of dry season I am supposed to participate in so many social festivities such as wedding, mahber, teskar[3] *and ametbal*[4]*. In all of these I am expected to prepare liemat*[5]*. So I have to prepare all the beverages and foods for each liemat and I may forget even my illness. When all this is over, the rainy season comes which demands a great deal of effort from each family members. So I do not have any free time throughout the year to go to health centers for treatment (Female in-depth interviewee, age 42).*

The other barrier that deterred visit to healthcare institutions was the belief that some diseases could not be treated by biomedicine. About 10.6% and 5% of respondents assumed they would not benefit from modern health services and did not visit healthcare institutions for treatment in that order. Some informants did not visit health care institutions for religious reasons:

I refused to go to healthcare institutions because I am old and nun since five years back. So I should pray and follow only one Lord. Paying visit to healthcare institutions would mean serving two Lords; God and Medical Doctor, which is impossible. Hence, I abandoned healthcare institutions. When I get pains I pray to God, use holy water and make massage with the holy Cross. These all produce relief (Female, age 73).

*I refuse to go to healthcare institutions when I become ill in this lent season [*the data collection was carried out during the lent season*] and in other fasting months. When you go there in such seasons, you will be forced to take medicine, obviously after food. That deters you*

[1]*Aregresa* is a well known herbaceous plant grown in the compounds of most rural homes and used as first option medicine for all maladies in the study area.

[2]*Borenk* is an Amharic term for a hard white stone like material, which after being dissolved is used to beautify the home of farmers. Rural dwellers called white tablets *borenk*, named after the similarity of color.

[3]*Teskar* is a commemoration ceremony to the deceased person (usually for adults) in his or her 40th or 80th day from the funeral.

[4]*Ametbal* is a religious or national festivity celebrated with festive meals.

[5]*Liemat* is the name for foods and beverages prepared by a household to participate in the social festivities like wedding, *teskar*.

to abide by the religious proscriptions. Indeed, if you were there in such periods you have committed a great sin. So I avoid visiting healthcare institutions at such periods no matter how much pain I experienced (Female in-depth interviewee, age 56).

Table 8: **Demand Side Barriers of Health Service Utilization**

What demand-side factors are preventing you from seeking health in health care facilities (Multiple Response is Possible)?	Frequency (N=180)	Percent of Responses	Percent of Cases
Perception of illness being not sever	129	22.39	71.7
Unable to pay medical expenses	154	26.74	85.6
Know how to deal with disease by my self	38	6.59	21.1
Do not have time	42	7.29	23.3
Do not feel to benefit from modern health services	19	3.29	10.6
I refused to visit healthcare facilities	9	1.57	5.0
Do not get support to go to health institutions	18	3.13	10.0
I visited herbalists	40	6.95	22.2
I used holy water	118	20.49	65.6
I visited local injectors	9	1.56	5.0
Total	576	100	320.1

About 10% and 22.2% of respondents respectively mentioned the demand side barriers such as lack of help from others to go to health institutions and visiting traditional healer instead of healthcare institutions respectively. About 10% of the respondents failed to visit healthcare facilities when there is no help from others.

There were diversified traditional healers in the study area, which serve a sizeable segment of patients. Traditional healers like *wegesha*[6], *asleflafi*[7], *tenkuay*[8] *and medihanitawaqi*[9] are part and parcel of the community. So, in the study area when one gets ill healthcare facilities are not the only options to get treatment.

Moreover, 5% of the respondents visited local injectors instead of health professionals to get relief from their illness. Although the number and acceptability of local injectors are declining in rural communities, their legacy on the perception of the community about the paramount importance of injection has transcended to today. One health professional narrated his experience about this as follows:

Almost all clients who come from rural areas for treatment need injection regardless of the nature of their illness. They urge you to give them injection since tablets are ineffectual to them. This was the legacy and impact of local injectors sow on rural communities. They are psychologically affected by what has been done to them by local injectors. If you gave them injection, and talk to them after a while, they said I am thankful for you. You healed me by the injection! (Male key informant, age 38)

One elderly informant added a similar story which magnifies what the health professional has narrated.

… I went to Mertulemariam health center to get treatment and the hakim (nurse) ordered me to take a packet of borenk. I begged him to change the borenk to injection, but he refused to do that. After a week I went to the health center again, because my pain persisted. I told the hakim to give me an injection and he did that. I felt better immediately after I had the first injection. I took the injection for seven days. At the end, I was relieved from my illness. It is injection which cures and not taking white tablets (male elderly informant, age 85).

Supply Side Barriers of Health Service Utilization*: The supply side barriers of health service utilization are those created by the institutions, professionals and policies, which have brought structural level barriers either inadvertently or deliberately in the service delivery process. The majority of respondents (86.1%) claimed there were unreasonable service charges in medical institutions which did not consider the economic capacity of the rural inhabitants. Next to unreasonable charges in medical institutions, long queuing and waiting time (43.3%), poor service and unfriendly treatment by health professionals (40.6%), distance of health institutions (36.7%) and complicated medical procedures (28.9%) were identified as the major supply side barriers of health service utilization.*

Healthcare institutions found in the study area are poorly equipped in terms of infrastructures and working equipment. One informant addressed the issue as follows:

I narrowly escaped death due to the complication I got while attending treatment by a nurse who was on apprenticeship in Bahir Dar town. She gave me medicine which was totally different from what was prescribed to me. When I felt a strange pain, the Doctor asked the nurse what she gave me and he came to know I was given the wrong medicine. Such services which are abruptly covered by the apprentice should have been carefully supervised by the experienced and senior professionals (male in-depth interviewee, age 47).

[6] *Wogesha* (bonesetters): a traditional expert known for fixing fractured bones and minor surgeries.
[7] *Asleflafi*: a person with supernatural or magical power to expel bad sprits like evil eye and Satan.
[8] *Tenkuay* is a witch doctor.
[9] *Medhanitawaki* (druggist) is traditional healer who prepares medicine from different plants leaf, root or stem.

Table 9: **Supply Side Barriers of Health Service Utilization**

What are the supply side barriers of using health services from healthcare institutions (Multiple Responses are Possible)?	Frequency (N=180)	Percent of Responses	Percent of Cases
High cost of service	155	36.56	86.1
Complicated medical procedures	52	12.27	28.9
Long queuing and waiting time	78	18.39	43.3
Poor service	73	17.21	40.6
Health institution far from home	66	15.57	36.7
Total	424	100	235.6

Another FGD participant from adult men narrated his experience about the services of the health centers in the *woreda* as follows:

The quality of the services provided by government healthcare facilities is wanting. The health professionals prescribe medicine for clients based on the information acquired from clients themselves without adequate examination of the illness. To your surprise, the medicines they prescribe are most of the time not found in the drug stores of the health centers and people are forced to purchase from private pharmacies, which are too costly for the rural inhabitants. Thus, lack of standardized services and medicine in health centers forced clients to visit private clinics, where better service is provided although costly. These accumulated grievances in the constituencies lead people to ignore healthcare institutions and look for other alternatives. We drag our feet from visiting healthcare institutions because of the concern for these poor services. For minor injuries, they refer clients to hospitals found in Motta or Bahir Dar. They simply say we could not treat this here!

Cultural Beliefs and Practices as Barriers of Health Seeking Behavior*:* There are a widespread customs and traditions practiced for a long period of time in the study area, which indirectly or directly inhibit health service utilization. A health extension worker narrated her observations about the cultural practices in the rural communities and how such practices prevented people from visiting healthcare institutions as follows:

People of the kebele in which I am working pay special tribute to the first day of the month called mebacha[10], and unfortunately if they are seriously ill on that day, they would definitely avoid visiting healthcare institution. The justification is that if they travelled somewhere on that day, they would travel throughout the month.

Another health extension worker seconded this view as follows:

In the rural communities there is widespread belief known as yebetamlak (god of the family) and when a family member becomes ill, they attribute to the anger of yebetamlak due to their failure to execute usual habits like slaughtering red got or hen (demmafses). This yebetamlak is thought to be incompatible with the medical services and the family is forced to look after traditional healer. In most cases people delay visiting healthcare institutions while trying to treat the illness by traditional healers and come to health centers as last resort.

Attitude and Health Service Utilization: About 62(34.4%) of respondents reported a negative attitude towards healthcare services, institutions and professionals, while the remaining 65.6% of them had positive attitude towards modern healthcare institutions. An inferential statistical T-test showed that rural inhabitants with positive attitude used healthcare institutions more frequently than those with negative attitude.

Seasonal and Infrastructural Barriers of Health Seeking Behavior: A combination of multiple factors has played a decisive role in predicting health seeking behavior of rural communities including seasons of the year. The seasons of the year are related to infrastructural barriers. During the rainy season, all the dirt roads become impassable by busses and other motorized vehicles. One health extension worker narrated her experience as follows:

In the kebele where I work, the ambulance could not come during the rainy seasonbecause of road problem. Thus, people are forced to carry a seriously sickperson by locally made stretcher. It is very difficult and time taking as the kebele is far from Mertulemariam health center. Pregnant women are also facing the same problem to get delivery service in health centers. If the road was repaired, the health seeking behavior of dwellers could have been boosted.

[10] *Mebacha*: the first day of every new month celebrated with coffee ceremony in rural areas. On *mebacha*, the house is cleaned and decorated/ dressed with paint or wet dung. It was made like that to express ones hope of being happy throughout the new month and to thank GOD for keeping the family from casualties in the old month and to do the same during the new one.

Table 10: **Attitude of Respondents towards Healthcare Services, Institutions and Professionals**

Attitude of Respondents	Frequency	Percent
Negative (10-27 Scores)	62	34.4
Positive (28-40 Scores)	118	65.6
Total	180	100.0
Mean=28.26 SD= 6.489	**Min=15**	**Max= 40**

The seasons of the year are also associated with income in rural dwellers. There was a general agreement that the rainy season is the period farmers experience shortage of food and money. This inhibited people from seeking healthcare services. Usually people wait until harvest time to go to health centers. One informant narrated his experience as follows:

I am suffering from recurrent rheumatism. I was unable to come to health centers during the rainy season due to lack of money. I get money after harvest, but I was delayed even after that because of lack of transportation. I came here today by using horse as means of transportation.

Moreover, according to one health professional, the nature of health seeking behavior of rural farmers goes up and down depending on the season. The professional described as follows:

During the rainy season, rivers get over flooded, roads become muddy, farmers debited with payment for fertilizer, and busy with farm activities that their health seeking behavior deteriorates compared with the dry season. In seasons when malaria is rampant many people come from rural areas for treatment. It is not only the economic earnings of rural dwellers that will be affected by the change in seasons of the year, but also their social life and social engagements. In the dry season beginning from January to May, rural people actively participate in extensive social festivities. The gathering of large number of people might create a fertile ground for the spread of communicable diseases like common cold, tuberculosis and others. These easily communicable diseases make large number of individuals vulnerable. The occurrence of such illnesses combined with the increase in their income in the dry season, motivates them to visit healthcare facilities as compared to the rainy season.

The farmers are also too busy during the rainy season and they do not have time to spare to visit health institutions unless it is serious illness that prevents them from farm work.

Discussion

The ideal measure of health service utilization in Western societies is a number of physician visits in one year (22). But, this measure does not work in the rural communities of Ethiopia due to the nonexistent of physicians in health centers, which are the destination for most rural dwellers to seek health service. Thus, the number of visit to healthcare institutions was considered as alternative measure of health service utilization.

Health service utilization is regarded as low in Ethiopia in general. A study conducted in Amhara region (18) reported that only 38.7% of the respondents used the available health services. In the present study, 58.9% of respondents utilized the existing health services from healthcare institutions found in their locality. A study conducted recently in several regions of Ethiopia (19) reported that although health service utilization is low, regional variation in health service use was considerable, with households in Amhara being most likely to seek higher level of care and those in SNNPR most likely to forego or delay seeking care. Although households in Amhara are better users of health services, they tended to delay visiting healthcare institutions unlike households of other regions.

The findings of this study identified the various predisposing, enabling and need factors related to healthcare service utilization. Factors such as sex, age, marital status and educational status are significantly affecting health service utilization of rural communities in many developing countries. A study conducted in rural Nepal (6) found that older persons and women tended to delay seeking modern healthcare longer than younger persons and men. On the other hand individuals who were to school took less time to seek modern health care services than individuals who had never been to school. A study carried out in rural Bangladesh (23) also came up with similar finding that literacy level of the household head had a significant role in seeking healthcare immediately after the onset of illnesses. The results of the present study have exhibited congruence with what has been reported in rural Nepal (6) and Bangladesh (23).

The findings of this study showed that health service utilization is influenced by sex and age. Studies conducted (24-26) indicated that women generally tend to use healthcare service compared to their men counterparts. Probably, the difference in healthcare service utilization of women and men could be explained by the type of diversified healthcare needs of the two sexes. It is, therefore, possible to conclude that women utilize healthcare services more often than men. The maternity services like pregnancy and delivery might have contributed to this difference.- Furthermore; the social values associated with masculinity traits like braveness and being strong could force men to resist the various common infectious illnesses without getting treatment from healthcare institutions. On the other hand, femininity traits could make women sensitive to every illnesses and rush to visit healthcare institutions. The finding of the present study showed slight difference from studies conducted in western societies concerning age and health service

utilization. A study conducted (27) found relative manifestation of health problems in the elderly resulted in relatively higher healthcare service utilization. But the elderly are the least users of health service in the current study. The findings of this study are, however, in line with a study in Amhara region of Ethiopia (18) which revealed that elderly are less likely to visit healthcare facilities. This difference might be due to the absence of health insurance and support for the older segment of the population in rural Ethiopia. Moreover, the elderly being more religious may suggest strong attachment with indigenous medicine which is physically and socially more accessible, less complex and bureaucratic, and above all, closer to their world view.

Marital status of respondents and family size characteristics were not associated with health service utilization in the present study, which is in line with a study conducted in rural Maori of New Zealand (28). But there was an association between health seeking behavior and marital status and family size in other studies (1). Marital status was not associated with the length of time taken to seek modern healthcare (6), but in the present study those married individuals were more likely to visit healthcare institutions sooner than the divorced and widowed. However, family size of respondents was not significantly associated with either health seeking behavior or health service utilization, unlike in previous studies. Fear of visiting healthcare institutions and attitude towards modern healthcare institutions, professionals and services were discussed as the strongest predictor of health service utilization and health seeking behavior in a study of African Americans (29). In the present study, individuals with negative attitudes about the efficacy of modern healthcare used the services less than those with positive attitudes about healthcare institutions, professionals and services.

Implications

The researchers would like to modestly contribute to policy debates on the quality of services delivered in healthcare facilities in Ethiopia. One fundamental factor for delays of health care seeking in rural setting has to do with among others lack of satisfactory health services in government health facilities. Therefore, the mushrooming health posts and health centres should be well equipped with sufficient and standardized equipment and qualified and disciplined professionals. Apprentice should be supervised and seriously examined by senior health professionals before joining health work force. The provision of standardized and qualified health services in the government healthcare facilities could have a down-to-earth effect in sustaining and reinforcing the enhanced health service use and health seeking behaviour of rural inhabitants.

Conclusion:

The findings of this study revealed that the health service utilization of rural households in Enebisie Sar Mider Woreda is fashioned by the interaction of multifarious factors unfolding in micro and macro level social fabrics. Unlike the behaviourist explanations, this study reveals that the determinants of health seeking behaviour do not evolve only from the micro level forces. The individual level factors are necessary, but not sufficient to explain health seeking behaviour of rural households. On the other hand, contrary to structuralist proponents, health service utilization of rural inhabitants could not be explained by structural and societal level factors alone. The present study takes middle-of-the-road position to explain the determinants of health service utilization of rural households. Neither agency reductionism nor structural determinism approach is adequate to explain health seeking behaviour independently. Thus, the combined effects of the individual and societal level factors could explain health service utilization better than the independent effect of these two explanations.

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